No. 87-545

In The
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1987

CESAR A. PERALES, as Commissioner of the New York State Department of Social Services,

Petitioner,

- against -

MILDRED KRIEGER,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE NEW YORK STATE COURT OF APPEALS

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether this Court lacks jurisdiction under Article III of the Constitution to review a judgment that no longer presents a case or controversy, the respondent Mildred Krieger having received all the disputed Medicaid benefits from the Commissioner of the New York City Department of Social Services, a party to the proceedings in the trial court below who did not appeal that court's adverse decision to the New York Court of Appeals or seek review in this Court?

2. Whether this Court is without jurisdiction to review a New York Court of Appeals judgment premised on an independent and adequate state law ground, to wit that a Medicaid eligible claimant who has promptly paid her bills is entitled under the New York Social Services Law and New York State case law to Medicaid reimbursement for medical expenses incurred three months prior to her application for Medicaid benefits?

3. Whether this Court should decline to review a state court judgment to the extent that it concerns the weight to be given a federal agency letter pursuant to the Administrative Procedure Act where that decision is supported by an independent federal law ground not challenged on certiorari, to wit that the Freedom of Information Act's publication requirement deprives the unpublished agency letter on which petitioner relies of any force and effect in determining the claimant's rights?

4. Whether, absent a conflict among the federal circuit courts or other state courts regarding an issue of limited significance and consequence, this Court should deny certiorari to review the New York Court of Appeals' unexceptionable rulings that (i) a Medicaid eligible claimant who promptly paid her bills is entitled to Medicaid coverage of the same amount,

duration and scope for the three months prior to the month of their application as a claimant who fail to pay her bills, and that (ii) an unpublished agency letter on which petitioner relies is of no binding force and effect in determining claimant's rights where that letter was not promulgated in accordance with the notice and comment rulemaking requirements of the Administrative Procedure Act?

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BRIEF IN OPPOSITION

Respondent respectfully submits this brief in opposition to the petition of the Commissioner of the New York State Department of Social Services for a writ of certiorari to review the judgment of the New York State Court of Appeals.

COUNTERSTATEMENT OF THE CASE

A. Introduction

Petitioner's selective statement of the case is misleading. First, petitioner fails to disclose that the Commissioner of the New York City Department of Social Services, who alone was ordered by the trial court to reimburse respondent

for her paid medical expenses, chose not to appeal from the original judgment and instead fully complied with the payment order. Accordingly, in its present posture, this case presents no case or controversy between the parties to this proceeding. Second, the decision of the New York State Court of Appeals was based independently and adequately on New York Social Services Law § 367-a(1) (McKinney 1983) and an uninterrupted line of state court cases interpreting that statute. This Court, therefore, is without jurisdiction to grant the petition. Finally, with respect to the challenge to the analysis of the Administrative Procedure Act, petitioner failed to disclose that the state court found the federal agency letter of no binding force or effect under the Freedom of Information Law, an alternate federal law ground uncontested by the State in its petition to this Court.

B. Statutory Scheme

The Medical Assistance Program ("Medicaid") is designed to meet the medical expenses of needy individuals who satisfy the program eligibility requirements. The United States Department of Health and Human Services ("HHS") is authorized to make payments under the Medicaid program to states whose plans conform to the specific requirements of Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq. (1983). New York State participates in the Medicaid program and receives federal funding under its state plan.[1] New York Social Services Law §§ 363 et seq.

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1 Federal law also requires that a state Medicaid plan be administered or supervised by a "single state agency." 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10 (1986). In New York, the petitioner, New York State Department of Social Services ("NYSDSS"), is the designated single state agency. The NYSDSS has delegated its authority to make initial eligibility determinations to local social services districts. In New York State each county comprises a social services district except the five counties of New York City which make up a single social services district. Each local social services district is headed by a county social services commissioner, or in the case of New York City, a city social services commissioner. Determinations made by the local Social Services Commissioners are reviewable by the State Commissioner through an administrative hearing. N.Y.

All participating States must provide Medicaid to all persons who fall within certain groups. These groups are referred to as the "categorically needy." In addition, States may choose to provide assistance to "medically needy" groups. If a group is covered as categorically or medically needy, the State must follow, at a minimum, all federal requirements.

Under New York's Medicaid program, elderly persons who would be eligible for benefits under the federal Social Security Income ("SSI") program but for their income and resources are a medically needy group. N.Y. Soc. Serv. Law § 366(1)(a)(5) (McKinney 1983). Accordingly this group must receive benefits in conformity with all federal and state requirements. The federal law requirements include provisions that Medicaid be furnished for care and services provided in or after the third month before the month in which the Medicaid application was made if the applicant was eligible for medical assistance at the time such care and services were provided. 42 U.S.C. § 1396a(a)(34); N.Y. Admin. Code tit. 18, § 360.16 (1986). In addition, payment must be made to an eligible individual or the person or institution which provides the medical service or care. 42 U.S.C. § 1396a(a)(32); N.Y. Soc. Serv. Law § 367-a. Such medical assistance to any individual shall not be less in amount, duration or scope than that made available to any other eligible individual. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. § 440.240(b). Finally, Medicaid must be provided to all eligible individuals with reasonable promptness. 42 U.S.C. § 1396a(a)(8); N.Y. Soc. Serv. Law §365; N.Y. Admin. Code tit. 18, § 360.14 (1986).

Nothing in state or federal law prohibits the State from providing medical assistance greater than that required under federal law, although the State may forgo reimbursement for such benefits. For example, the New York State Medicaid plan provides for an income deduction for which there is no parallel federal

Admin. Code tit. 18, §358 (1983).

law provision, N.Y. Soc. Serv. Law § 366(2)(a)(7), and for certain reimbursable family planning services for which there is no federal reimbursement, N.Y. Admin. Code tit. 18, § 505.13 (1986).

C. Facts

Respondent Mildred Krieger is an 81-year-old widow who suffers from angina pectoris, hypertension, glaucoma, a duodenal ulcer, and severe arthritis. Mrs. Krieger is under the continuous care of physicians and takes prescription medications for her various ailments. Mrs. Krieger's sole source of income at the time of her Medicaid application was a Social Security widow's benefit in the amount of $420 per month. From this limited income, respondent was required to meet all her living expenses, including those for food, rent, utilities and clothing. In addition, unaware of the procedures in the Medicaid program or of her right to receive medical assistance benefits, Mrs. Krieger was paying her medical bills out of her monthly Social Security check and her small savings account in the months prior to applying for medical assistance. Medicaid reimbursement to Mrs. Krieger for her payment of those covered services was to become the issue presented in this litigation.

Respondent Mildred Krieger applied for Medicaid through a local office of the New York City Department of Social Services ("local agency"). When the local agency failed to make an eligibility determination within 30 days as required by state regulation,[2] respondent commenced a state mandamus proceeding pursuant to Article 78 of the New York Civil Practice Law and Rules against the Commissioners of the New York City and New York State Departments of Social Services to compel them to provide her with Medical Assistance, and to reimburse her for

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2 N.Y. Admin. Code tit. 18, § 360.14 (1986).

out-of-pocket medical expenses.[3]

Through a state administrative hearing and a subsequent Stipulation of Partial Settlement in the mandamus proceeding, all of the issues raised in respondent's original and amended petitions were resolved,[4] except the issue of respondent's entitlement to reimbursement for medical expenses incurred and paid for during the three months prior to the month of her application.

The state trial court, relying exclusively on state law, determined that New York Social Services Law § 367-a(1) did not prevent direct reimbursement to the respondent and that the State Commissioner's failure to order reimbursement for claimed medical expenses was "arbitrary and capricious."[5] The court, accordingly, ordered the local agency to reimburse respondent for medical bills incurred and paid for in the three months prior to applying for Medicaid. Matter of Krieger v. Krauskopf, 126 Misc. 2d 70, 481 N.Y.S.2d 219 (Sup. Ct. 1984).

The local agency chose not to appeal from the lower state

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3 Article 78 of the New York Civil Practice Law and Rules is the state proceeding available to individuals to challenge a determination of an administrative officer or body to obtain the relief previously available through the common law writs of certiorari, mandamus and prohibition. N.Y. Civ. Prac. Law § 7801 et seq. (McKinney 1981).

4 As a combined consequence of the Decision After Fair Hearing and the Stipulation of Partial Settlement, respondent was found to be eligible for Medicaid from February 1, 1983, the third month prior to the month of her application, through June 30, 1983, after incurring medical expenses of $19.80 for each of those months. She was also determined to be eligible for Medicaid beginning July 1, 1983 without the need to incur any medical expenses. Furthermore, the local agency agreed to, and in fact did, reimburse respondent directly for all medical expenses which she incurred and paid for out of exempt income and resources except those incurred during the three months prior to the month of her application.

5 The "arbitrary and capricious" finding by the state court is a direct reference to the state law Article 78 proceeding. See supra note 3. Among those questions reviewable in an Article 78 proceeding are "whether a determination was made in violation of lawful procedure, was affected by an error of law or was arbitrary and capricious or an abuse of discretion . . . ." N.Y. Civ. Prac. Law § 7803 (emphasis supplied).

court's judgment, thereby binding itself to the mandate of the court. Accordingly, the local agency issued a check to respondent for $139.15 (a copy of which is annexed hereto as Appendix "A") in full compliance with that judgment.

The State Commissioner, however, did appeal. On appeal, the Appellate Division of the Supreme Court of the State of New York affirmed, finding no valid basis for denying respondent direct reimbursement for paid medical expenses. "To hold otherwise," the court stated, "would lead to the creation of two classes of Medicaid recipients, one of which would receive fewer benefits solely because members of the class paid their medical bills promptly, and the other which would receive greater benefits by way of reimbursement to the providers of medical services because the members of the class did not pay their medical bills promptly." Matter of Krieger v. Krauskopf, 121 A.D.2d 448, 450, 503 N.Y.S.2d 418, 420 (2d Dep't 1986). The court rested its decision to reimburse Mrs. Krieger for her paid medical expenses on Section 367-a of the New York Social Services Law, and the state decisional law construing that statute, which provides that payment for medical services be made to the provider of services, except as here, where reimbursement directly to the recipient of the medical services is required under state law. The court subsequently noted that federal law offers "further support" for its conclusion; federal law may also require the direct reimbursement to Mrs. Krieger for medical expenses incurred and paid for in the three months prior to the month of her application for Medicaid. In this regard, the court also stated that it was not bound to follow the federal agency's unpublished letter directive, ruling that the letter announced a substantive rule and was not entitled to full force and effect because it was not promulgated pursuant to the notice and comment provisions of the Administrative Procedure Act or alternatively, if the letter

announced an interpretive rule, HHS' failure to publish the rule in the Federal Register, as required by the Freedom of Information Act of all interpretive rules which adversely affect citizens' rights, precludes the enforcement of the interpretive rule against Mrs. Krieger. Matter of Krieger v. Krauskopf, 121 A.D.2d at 450-451, 503 N.Y.S.2d at 421. The New York Court of Appeals affirmed and adopted the decision of the Appellate Division. Matter of Krieger v. Krauskopf, 70 N.Y.2d 637, 512 N.E.2d 540, 518 N.Y.S.2d 957 (1987).

REASONS FOR DENYING THE WRIT

In his petition the Commissioner of the New York State Department of Social Services asks the Court to render an advisory opinion on the propriety of dicta in a decision based on an independent, adequate, and uncontested state law ground, concerning matters as to which there is no live controversy between the parties. Prudential considerations and jurisdictional requirements compel the denial of the petition for certiorari in this case.

I. BECAUSE ONE PARTY TO THIS LITIGATION LACKS A PERSONAL STAKE IN THE OUTCOME OF THE PROCEEDING, THE PETITION PRESENTS NO CASE OR CONTROVERSY SUFFICIENT TO ESTABLISH JURISDICTION UNDER ARTICLE III OF THE CONSTITUTION.

Respondent Mildred Krieger commenced this action against the New York City and New York State Departments of Social Services in July, 1984, to obtain reimbursement for $139.15 which she spent on health care in the three months prior to the month of her application for Medicaid. The state trial court entered judgment for Mrs. Krieger, granting her petition and ordering the New York City Department of Social Services ("local agency") to reimburse her for paid medical expenses incurred during the contested period.[6] The New York City Department of Social Services chose not to appeal the trial court's decision, and instead, complied with the judgment by paying Mrs. Krieger the full amount of benefits for which she had sued in the trial court. The check is attached as Appendix "A".

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6 In so ruling, the trial court annulled so much of the September 13, 1984 decision of the Commissioner of the New York State Department of Social Services as refused to direct the local agency to reimburse Mrs. Krieger for the monies sought in the petition.

In its present posture, this case presents no matter in controversy between the two parties to this litigation because Mrs. Krieger has no dispute with the petitioner State Commissioner.[7] Mrs. Krieger was reimbursed by the local agency -- not a party at this stage of the proceedings -- for the monies she spent. Any wrongs against her have been fully redressed and there is no likelihood that she will be confronted with this situation again. She has nothing further to litigate and no stake in the ultimate outcome of this proceeding. Even if the state court judgment were reversed, Mrs. Krieger could not be required to refund the monies issued by the local agency; the City Department of Social Services lost any claim it may have had to the reimbursed money when it declined to exercise its appellate rights. See Federated Department Stores, Inc. v. Moitie, 452 U.S. 394, 398 (1981). Where one of two remaining parties to litigation utterly lacks a personal stake in the outcome of the proceeding, Article III of the United States Constitution, as well as prudential considerations, compel this Court to decline jurisdiction and to deny the petition for a writ of certiorari.[8] Preiser v. Newkirk, 422 U.S. 395, 401 (1975);

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7 There is no counterpart to the Article III case or controversy requirement in the New York State Constitution. The New York State appellate courts, therefore, were free to determine the State Department of Social Services' appeal even in the absence of a case or controversy between the parties. Appellate determinations are frequently rendered in such cases where a question of public importance is presented. Matter of Adirondack League Club v. Board of Black River Regulating District, 301 N.Y. 219, 222, 93 N.E.2d 647, 649 (1950), Matter of Lyon Co. v. Morris, 261 N.Y. 497, 499, 185 N.E. 711 (1933). See also Cohen and Karger, Powers of the New York Court of Appeals § 99, pp.420-421 (1951).

8 Furthermore, although not crucial to the outcome here, the petitioner has demonstrated no concrete financial interest in the outcome of his current dispute with Mrs. Krieger and has alleged none. In this case, the local agency chose to reimburse Mrs. Krieger pursuant to the state court order. The local agency has the authority to forgo federal reimbursement and pay out Medicaid benefits that are not approved by the State. Holley v. Lavine,

Indianapolis School Commissioners v. Jacobs, 420 U.S. 128, 129 (1975); SEC v. Medical Committee for Human Rights, 404 U.S. 403 (1972).

The exercise of judicial power under Article III of the Constitution depends on the existence of a case or controversy at all stages of review. Mrs. Krieger no longer has an adversary interest in the outcome of this proceeding. Furthermore, the petitioner's interest in this proceeding is speculative. The petition for a writ of certiorari should be denied. Preiser v. Newkirk, 422 U.S. at 401-402.

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605 F.2d 638, 643-645 (2d Cir. 1979) cert. denied sub nom., Blum v. Holley, 446 U.S. 913 (1980); Calkins v. Blum, 511 F. Supp. 1073, 1099 (N.D.N.Y. 1981), aff'd and remanded, 675 F.2d 44 (2d Cir. 1982). See Matter of Jones v. Berman, 37 N.Y.2d 42, 55, 332 N.E.2d 303, 310, 371 N.Y.S.2d 422, 431 (1975). Because the local agency fully paid Mrs. Krieger's disputed medical expenses, the State's adversarial interest is speculative, at best. In essence, therefore, the Commissioner of the New York State Department of Social Services has petitioned this Court in search of an advisory opinion to review the merits of the New York Court of Appeals decision. The Court is without jurisdiction under Article III to render advisory opinions or to decide questions that cannot affect the rights of litigants in the case before it. Preiser v. Newkirk, 422 U.S. 395, 401 (1975), quoting North Carolina v. Rice, 404 U.S. 244, 246 (1971).

II. THIS COURT IS WITHOUT JURISDICTION TO REVIEW A NEW YORK COURT OF APPEALS JUDGMENT PREMISED ON AN ENTIRELY INDEPENDENT AND ADEQUATE STATE GROUND, TO WIT THAT UNDER THE NEW YORK SOCIAL SERVICES LAW AND NEW YORK STATE CASE LAW, MEDICAID ELIGIBLE CLAIMANTS WHO HAVE PROMPTLY PAID THEIR BILLS ARE ENTITLED TO MEDICAID REIMBURSEMENT FOR MEDICAL EXPENSES INCURRED THREE MONTHS PRIOR TO THEIR APPLICATION FOR MEDICAID BENEFITS.

This Court is without jurisdiction to issue a writ of certiorari in this case because the decision of the New York Court of Appeals is based on an independent and adequate state law ground. Specifically, the New York court's judgment requiring direct reimbursement of the medical expenses incurred and paid by Mrs. Krieger in the three months prior to the month of her application for medical assistance is clearly based on settled state decisional authority interpreting New York Social Services Law § 367-a(1) (McKinney 1983). See Michigan v. Long, 463 U.S. 1032, 1042 (1983).

Section 367-a(1) of the Social Services Law provides that payment for medical services under the state Medicaid program be made to the provider of such services "except as otherwise permitted or required by applicable federal and state provisions, including the regulations of the [New York State] [D]epartment [of Social Services]." In this case, as in other similar circumstances, the New York State courts have read this "exceptions" clause of Section 367-a(1) to require direct reimbursement of medical payments made by Mrs. Krieger under the state Medicaid plan. The court cited other state court decisions which required direct payment of benefits to Medicaid applicants in other contexts, and ruled that state case law should be extended "by parity of reasoning" to situations where a Medicaid applicant incurs and pays for medical expenses in the three

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9 For example, in Matter of Lustig v. Blum, 80 A.D.2d 558, 435

months prior to the month of her application.[9] Matter of Krieger v. Krauskopf, 121 A.D.2d 448, 450, 503 N.Y.S.2d 418, 420, aff'd, 70 N.Y.2d 637, 518 N.Y.S.2d 957, 512 N.E.2d 540 (1987).

The Commissioner may not by sleight-of-hand transform this state law ground for requiring reimbursement of Mrs. Krieger's medical expenses into a federal law question. Cf. Oberlander v. Perales, 740 F.2d 116, 119 (2d Cir. 1984); Canaday v. Koch, 608 F.Supp. 1460, 1472 (S.D.N.Y.), aff'd, 768 F.2d 501 (2d Cir. 1985). Any conclusion to the contrary "would provide a jurisdictional basis for federal judicial review of every disputed state administrative ruling relating to Medicaid." Oberlander v. Perales, 740 F.2d at 119.

Although a state may not adopt a more restrictive Medicaid program than that required by the Social Security Act and regulations promulgated thereunder, and then expect federal reimbursement, see Townsend v. Swank, 404 U.S. 282, 286 (1971), it may adopt, as it has done here, a program that is more generous than those required by the federal guidelines and assume the costs of such programs forgoing federal reimbursement. See ante, p. 3. Matter of Cheng San Chen v. Toia, 67 A.D.2d 1085, 1086, 415 N.Y.S.2d 169, 170 (4th Dep't 1979), aff'd, 50 N.Y.2d

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N.Y.S.2d 350 (2d Dep't 1981), the state court determined that a Medicaid applicant was entitled to retroactive reimbursement for funds expended for her medical care due to the local agency's delay in approving the applicant's Medicaid application. The court rested its decision exclusively on state law, and summarily rejected the Commissioner's contention that the Social Services Law § 367-a categorically prohibits direct reimbursement to a Medicaid recipient in all situations. Similar in reasoning is Matter of Cole v. Wyman, 40 A.D.2d 1033, 338 N.Y.S.2d 964 (2d Dep't 1972), in which the state court referred only to state Medicaid regulations in support of its decision to require reimbursement to a Medicaid recipient for medical services provided and paid for during a period of Medicaid eligibility but before the eligibility determination was actually made. For other New York State court decisions on this issue, see e.g., Matter of Schwartz v. Toia, 68 A.D.2d 890, 414 N.Y.S.2d 23 (2d Dep't 1979) (reimbursement required pursuant to state law for cost of nursing home care where application for Medicaid was erroneously denied); Sockin v. Overcash, 45 A.D.2d 717, 356 N.Y.S.2d 329 (2d Dep't 1974) (reimbursement required under state law and "in the interests of justice" where two-and-a-half years elapsed between a prior Medicaid application which was lost by the local agency and a subsequent eligibility determination).

826, 430 N.Y.S.2d 50, 407 N.E.2d 1346 (1980). Cf. Harris v. McRae, 448 U.S. 297, 311 n. 16 (1980); Beal v. Doe, 432 U.S. 438, 447 n.15 (1977). Therefore, even if the Court of Appeals' interpretation of Section 367-a of the Social Services Law should have the effect of conferring greater benefits to Mrs. Krieger than federal law may require, it does not implicate federal rights or duties, but rather only dictates that such payments are not federally reimbursable.

Thus, the Commissioner cannot succeed in invoking this Court's jurisdiction simply by claiming that federal law prohibits direct reimbursement to a Medicaid recipient where it is clear that state law, independent and exclusive of federal law, mandates direct reimbursement to the Medicaid recipient under the facts of this case. Michigan v. Long, 463 U.S. at 1041-1042; see O'Brien v. Skinner, 414 U.S. 524, 531 (1974); see also Agins v. Tiburon, 447 U.S. 255, 259 n.6 (1980). Accordingly, the presence of an independent and adequate state law ground supporting the judgment of the New York court compels the denial of the petition for certiorari.

III. CERTIORARI TO REVIEW THE EFFECT OF THE ADMINISTRATIVE PROCEDURE ACT ON THE WEIGHT ATTRIBUTED TO AN UNPUBLISHED AGENCY LETTER IS INAPPROPRIATE IN THIS CASE BECAUSE THE STATE COURT DECISION ON THAT ISSUE IS SUPPORTED BY AN INDEPENDENT AND ADEQUATE FEDERAL LAW GROUND, NOT CONTESTED BY PETITIONER HERE, TO WIT THAT THE PUBLICATION REQUIREMENTS IN THE FREEDOM OF INFORMATION ACT DEPRIVE THE UNPUBLISHED LETTER ON WHICH PETITIONER RELIES OF ANY FORCE OR EFFECT IN DETERMINING THE BENEFITS DUE RESPONDENT.

Petitioner relied in the state courts on an unpublished letter from the Regional Medicaid Director of the Department of Health and Human Services ("HHS") which interprets the Medicaid statute to withhold reimbursement from persons such as Mrs. Krieger who paid their bills promptly.[10]

The court below properly refused to give full force and effect to the agency interpretation on two independent grounds, only one of which -- the Administrative Procedure Act -- is challenged by the petitioner in this Court. First, the state court concluded that the HHS letter announced a substantive rule prohibiting reimbursement in the circumstances of this case, and therefore could only be binding if it were promulgated in accordance with the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"), 5 U.S.C. § 553 (1977). Because the letter rule was never promulgated pursuant to the APA, the New York Court of Appeals found that the HHS letter is of no force and effect. Matter of Krieger v. Krauskopf, 70 N.Y.2d 637, 518 N.Y.S.2d 957, 512 N.E.2d 540 (1987), affirming, Matter of Krieger v. Krauskopf, 121 A.D.2d 448, 503 N.Y.S.2d 418 (2d Dep't 1986). See Buschmann v. Schweiker, 676 F.2d 352, 355-356 (9th Cir. 1982); Carter v. Blum, 493 F. Supp. 368, 372 (S.D.N.Y. 1980).

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10 It is undisputed that the HHS letter was never published in the Federal Register.

In the alternative, and assuming arguendo as petitioner argues here that the HHS letter announced an interpretive rule, the New York Court of Appeals found that HHS' failure to publish the rule in the Federal Register, as required by the Freedom of Information Act ("FOIA") of all interpretive rules adversely affecting citizens' rights, precludes the enforcement of the interpretive rule against Mrs. Krieger inasmuch as the rule clearly would have adversely affected her.[11]

Petitioner seeks review of the state court's treatment of the unpublished agency letter only with respect to the New York Court of Appeals' interpretation of the Administrative Procedure Act, to withhold binding effect from the Regional Director's unpublished letter. Petitioner does not contest the New York court's identical "no binding effect" conclusion based on the Freedom of Information Act. This Court does not sit to review dicta in state court decisions that reach correct results on unchallenged, alternative and wholly adequate and independent grounds. Accordingly, because the New York Court of Appeals correctly found the letter of no legal force and effect under the unimpeached and unappealed FOIA ground, that court's obiter dicta with regard to the APA issue is irrelevant to the outcome of the case and provides no basis for review by the Court.

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11 See 5 U.S.C. § 552(a)(1)(D) (1977); Morton v. Ruiz, 415 U.S. 199, 233 (1974). The Freedom of Information Act ("FOIA") requires the publication in the Federal Register of "substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency . . . " 5 U.S.C. § 552(a)(1)(D). The Act further states that a person may not be adversely affected in any manner by matter required to be published in the Federal Register and not so published. 5 U.S.C. § 552(a)(1). Anderson v. Butz, 550 F.2d 459, 463 (9th Cir. 1977); see Donovan v. Wollaston Alloys, Inc., 695 F.2d 1, 9 (1st Cir. 1982). The state court in this case concluded that Mrs. Krieger would be adversely affected by the provision contained in the HHS letter, that she had no actual or timely notice of that provision, and therefore, absent publication, the alleged rule could have no force or effect with respect to her.

IV. THIS COURT SHOULD DECLINE TO EXERCISE ITS JURISDICTION TO REVIEW THE NEW YORK COURT OF APPEALS DECISION BECAUSE THAT COURT'S JUDGMENT CREATES NO CONFLICT AMONG THE FEDERAL CIRCUIT COURTS OR OTHER STATE COURTS, RAISES NO IMPORTANT OR SIGNIFICANT FEDERAL LAW QUESTIONS, AND WAS CORRECTLY DECIDED.

The federal law dicta in the New York Court of Appeals' decision supporting the direct reimbursement to Mrs. Krieger for medical bills paid in the three months prior to the month in which she applied for Medicaid does not raise a novel or substantial federal question worthy of the exercise of this Court's jurisdiction. Significantly, petitioner does not allege that there are state or federal court decisions which concern this issue, or which conflict with the New York court's decision, because there are none reported. Nor does petitioner allege a substantial adverse financial or other impact on the administration of the State's Medicaid plan as a result of this litigation. Nor can petitioner substantiate his assertion that all states will be required to follow the New York Court of Appeal's decision with respect to the New York State Medicaid plan if the decision below is upheld, because the state court decision has no impact on the interpretation of any other state Medicaid plan. Petitioner's utter failure to identify or substantiate any far-reaching consequences of the New York Court's decision belies its bald assertion that the questions presented merit review by this Court. Furthermore, as explained below, the New York Court of Appeals' decision is correct. Accordingly, certiorari should be denied.

A. MEDICAID ELIGIBLE CLAIMANTS WHO PROMPTLY PAID THEIR BILLS ARE ENTITLED TO MEDICAID COVERAGE OF THE SAME AMOUNT, DURATION AND SCOPE FOR THE THREE MONTHS PRIOR TO THEIR APPLICATION AS THOSE CLAIMANTS WHO FAIL TO PAY THEIR BILLS.

Petitioner's refusal to direct the local agency to reimburse Mrs. Krieger for medical expenses incurred during the three months prior to the month of her Medicaid application violates the mandatory requirements of the federal Medicaid program. Under 42 U.S.C. § 1396a(a)(34) a State plan for Medicaid must provide:

> that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application . . .

42 U.S.C § 1396a(a)(34). By its terms, 42 U.S.C. § 1396a(a)(34) requires assistance to persons, such as Mrs. Krieger, who have been determined to be eligible for medical assistance and to whom care and services were furnished. The statute provides no basis for excepting care and services solely on the ground that the eligible claimant chose to pay bills promptly rather than face the potential loss of necessary care. By adding the condition that bills be unpaid, petitioner has interposed an illegal and unauthorized condition of eligibility. See generally King v. Smith, 392 U.S. 309, 333 n.34 (1968).

Indeed the legislative history of 42 U.S.C. § 1396a(a)(34) demonstrates that Congress was particularly concerned with the practical problems Medicaid eligible persons have in filing applications before they receive treatment. Prior to 1972, coverage for the three months prior to application was optional and only thirty-one states provided such coverage. In making 42

U.S.C. § 1396a(a)(34) a mandatory part of any State Medicaid plan, Congress recognized that many Medicaid eligible claimants "do not apply for assistance until after they have received care, either because they did not know about Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying." H.R. Rep. No. 92-231, 92d Cong., 2d Sess. reprinted in [1972] U.S. Code Cong. & Ad. News 4489, 5099. Because Congress found coverage for these earlier months to be both "reasonable and desirable," id., it required all states to provide such coverage. Congress' express intent that eligibility not be denied due to a delay in applying for Medicaid is clearly frustrated by petitioner's arbitrary rule that penalizes eligible claimants who paid their bills promptly out of fear of losing essential medical care.

The singling out of claimants who have paid their bills likewise violates the Social Security Act's mandatory requirement that State plans set forth a single standard for determining the amount, duration and scope of assistance within any group of persons eligible for medical assistance. See 42 U.S.C. §§ 1396a(a)(10)(B), 1396a(a)(10)(C). Similarly, 42 U.S.C. § 1396a(a)(17) requires that state plans include reasonable standards that are comparable for all groups determining the extent of medical assistance and that are consistent with the objectives of the Medicaid statute. As set forth in federal regulations, a State plan:

> must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:
> * * *
> (2) A covered medically needy group.

42 C.F.R. § 440.240(b) (1986). This comparability requirement mandates that Mrs. Krieger receive care in the same amount,

duration and scope as a similarly situated person who has not paid her bills. See Hodecker v. Blum, 525 F. Supp. 867, 873 (N.D.N.Y. 1981), aff'd, 685 F.2d 424 (2d Cir. 1982). It does not permit Mrs. Krieger to be penalized for simply paying her bills on time.

In this case, Mrs. Krieger has been found to be "medically needy" for the three months prior to her application date. Under the facts of this case stipulated to below, she is eligible to receive Medicaid for any month in which she has incurred $19.80 in medical expenses. In fact, Mrs. Krieger's expenses were in excess of $19.80 for each of those three months. Had she not paid her bills, the provider of medical services admittedly would have been reimbursed. By not reimbursing Mrs. Krieger for the very same bills petitioner would have otherwise paid, petitioner is denying Mrs. Krieger the same amount, duration and scope of medical assistance provided to persons who are identically situated but who have not paid their bills.

B. AN UNPUBLISHED AGENCY LETTER NOT PROMULGATED IN ACCORDANCE WITH THE NOTICE AND COMMENT RULEMAKING REQUIREMENTS OF THE ADMINISTRATIVE PROCEDURE ACT IS OF NO BINDING FORCE AND EFFECT IN DETERMINING CLAIMANTS' RIGHTS.

With respect to its Administrative Procedure Act ("APA") claim, petitioner argued inconsistently that although the HHS letter is merely an interpretation of the agency's regulation and therefore exempt from the notice and comment provisions of the Administrative Procedure Act, 5 U.S.C. § 553 (1977), it is nevertheless binding law upon the courts and the parties as an authoritative interpretation of federal statutory law.[12] [13] The

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12 This argument was raised by petitioner on appeal to the New York Court of Appeals in a footnote. Petitioner did not raise a specific objection to the lower state court's interpretation of the Freedom of Information Law, 5 U.S.C. § 552, on appeal to the New York Court of Appeals.

13 A substantive rule is defined as a "legislative type rule .

petitioner misconstrues the decision of the New York court to create an alleged conflict among the federal circuit courts. Petitioner characterizes the New York Court of Appeals decision as holding that interpretive rules must be promulgated as a regulation pursuant to the APA in order to be given force and effect. In fact, the New York Court of Appeals never addressed the bearing of the APA on interpretive rules because it concluded in its APA analysis that the HHS letter was a substantive rule.[14]

Substantive rules clearly and unequivocally fall within the ambit of the APA notice and comment provision, 5 U.S.C. § 553, and will not "be afforded the 'force and effect of law' if not promulgated pursuant to the statutory procedural minimum found in th[e] [Administrative Procedure] Act." Chrysler Corp. v. Brown, 441 U.S. 281, 313 (1979). On this point, there is no disagreement among the petitioner, the respondent, the New York Court of Appeals, and the federal courts. See e.g., St. Mary's Hospital of Troy v. Blue Cross & Blue Shield Ass'n, 788 F.2d 888, 891 (2d Cir. 1986); Linoz v. Heckler, 800 F.2d 871, 877 (9th Cir.1986); Smith v. Miller, 665 F.2d 172, 179 n.7 (7th Cir. 1981); Cerro Metal Products v. Marshall, 620 F.2d 964, 981-982 (3d Cir. 1980); Columbus Community Hospital, Inc. v. Califano, 614 F.2d 181, 187 (8th Cir. 1980); Anderson v. Butz, 550 F.2d 459, 463 (9th Cir. 1977).

Nor is there a conflict between the New York Court of

. . as one 'affecting individual rights and obligations.'" Chrysler Corp. v. Brown, 441 U.S. 281, 302 (1979), quoting Morton v. Ruiz, 415 U.S. 199, 236 (1974), which purports to be binding on the agency, Batterton v. Marshall, 648 F.2d 694, 702 (D.C. Cir. 1980), and which has "the force and effect of law." Batterton v. Francis, 432 U.S. 416, 425 n.9 (1977); National Nutritional Foods Ass'n. v. Weinberger, 512 F.2d 688, 698 n.8 (2d Cir.), cert. denied, 423 U.S. 827 (1975). Therefore, if the HHS letter is read as binding agency policy, it meets the description of a substantive rule set out by this Court and the lower courts.

14 The HHS letter purports to interpret a provision in the HHS Medicaid Manual. A section of this Medicaid Manual is annexed to the Petition for a Writ of Certiorari as Appendix "F" in an attempt to make it part of the record. The HHS Medicaid Manual was not introduced and is not part of the record below. It therefore should not be considered at this time.

Appeals and the federal circuits with respect to the deference accorded to administrative interpretations. If the HHS letter is only an interpretive rule -- one "which merely clarif[ies] or explain[s] existing law or regulations," Powderly v. Schweiker, 704 F.2d 1092, 1098 (9th Cir. 1983) -- it is by definition "non-binding," Batterton v. Marshall, 648 F.2d 694, 702 (D.C.Cir. 1980), and is not entitled to the type of judicial deference accorded regulations promulgated pursuant to the notice and comment provisions of the APA. See Schweiker v. Hansen, 450 U.S. 785, 789-90 (1981); Liegl v. Webb, 802 F.2d 623 (2d Cir. 1986) (The Medical Assistance Manual merely provides operational assistance without intending to supplement regulations and is not entitled to particular deference.)

Varying degrees of deference are accorded to administrative interpretations based on a number of factors, most notably the consistency of the agency's position. Batterton v. Francis, 432 U.S. 416, 425 n. 9 (1977); General Electric v. Gilbert, 429 U.S. 125, 141-143 (1976). As the record below establishes, petitioner decidedly has not consistently enforced the administrative interpretation it invokes in this Court. For example, reimbursement was made to the respondent in this very case for prescription drugs which petitioner claimed in the Court of Appeals, relying on the Regional Director's letter, cannot be the subject of reimbursement. See supra note 9. Administrative guidelines are properly discounted where as here they conflict with earlier pronouncements of the agency. General Electric v. Gilbert, 429 U.S. at 143; United Housing Foundation, Inc. v. Forman, 421 U.S. 837, 858 n. 25 (1975); Morton v. Ruiz, 415 U.S. 199, 237 (1974); Espinoza v. Farah Mfg. Co., 414 U.S. 86, 93-94 (1973).

The petitioner cannot have it both ways. If the HHS letter states a substantive rule, it is void for failure to comply with

the notice and comment provisions of the Administrative Procedure Act, 5 U.S.C. § 553. If, on the other hand, it is an interpretive rule, it lacks binding authority, and is not entitled to slavish deference by the reviewing court. The New York Court of Appeals decision is consistent with the federal circuits on these points. Certiorari is unwarranted.

CONCLUSION

For the reasons set forth above, the writ of certiorari should be denied.

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